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In The

Supreme Court of the United States

October Term, 1996

DENNIS C. VACCO, Attorney General
of the State of New York, *et al.*,
Petitioners,

v.

TIMOTHY QUILL, M.D., *et al.*,
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

STATE OF WASHINGTON, *et al.*,
Petitioners,

v.

HAROLD GLUCKSBERG, M.D., *et al.*,
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF *AMICUS CURIAE* OF STATE LEGISLATORS IN SUPPORT OF RESPONDENTS

MICHAEL C. DORF
435 West 116th Street
New York, New York 10027
(212) 854-2672

SHERRY F. COLB
Counsel of Record
15 Washington Street
Newark, New Jersey 07102
(201) 648-1127

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Interest of Amici[1]

Amici are members of the legislatures of sixteen States, including New York and Washington. Within our federal system, amici recognize that their obligations as representatives of the People of the several States must coexist with their sworn duty to uphold the Constitution of the United States. Mindful of that duty, amici seek a ruling in this case that preserves both the essential attributes of state sovereignty and the supremacy of federal law. With due respect, the position advocated in this Court by the petitioners and their amici distorts our system of dual sovereignty beyond recognition. Their position implies that to protect a constitutional right is to interfere with state sovereignty. However, especially in a case such as this one -- in which significant room exists for reasonable state regulation that does not infringe the core right asserted -- protection of the constitutional right preserves the proper balance of authority between representative government and constitutional safeguards.

Statement of the Case and Summary of Argument

The States of New York and Washington impose criminal liability on physicians who provide death-inducing medication to mentally competent, terminally ill patients seeking to assert some measure of autonomy over the waning months, weeks or days of their lives. *See* N.Y. Penal Law § 120.30 (McKinney 1987); Wash. Rev. Code Ann. § 9A.36.060 (West 1988). The Courts of Appeals for the Second and Ninth Circuits held that these statutes, respectively, violate the Equal Protection and Due Process Clauses of the Fourteenth Amendment, as applied to physicians and patients in respondents' circumstances. *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996); *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996) (en banc).

Although the state prohibitions at issue here take the nominal form of a failure to provide an exemption from the States' general prohibition on assisting suicide, these cases no more involve an asserted "right to suicide" than an as-applied challenge to a State's

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[1] The parties' letters consenting to the filing of this brief have been filed with the Court. *See* Sup. Ct. R. 37.3. A list of the amici appears in Appendix B to this brief.

failure to exempt pre-viability abortions from its prohibition on homicide would involve a "right to murder." Rather, these cases raise the question whether the States may require that an individual's final stage of life be filled with suffering without proffering any stronger justification for failing to adopt more measured safeguards than that such complete prohibitions were "laid down in the time of Henry IV." Holmes, *The Path of the Law*, 10 Harv. L. Rev. 457, 469 (1897).

This Court has long recognized that the State must offer some special justification for seeking to control central, intimate, personal decisions. *See Planned Parenthood v. Casey*, 505 U.S. 833 (1992). Indeed, in *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990), the Court assumed "[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment," including lifesaving food and water. *Id.* at 278. That assumption was an express condition of the concurrence of the fifth Justice. *See id.* at 289 (O'Connor, J., concurring).

From the perspective of a suffering patient, the interest at stake in seeking medication for the purpose of causing death does not differ from the interest at stake for a patient who, for the purpose of causing death, seeks to discontinue a course of medical treatment. To be sure, there are circumstances in which the State may distinguish between, on the one hand, refusing medical treatment and, on the other, bringing about death through other means. But it hardly follows that the State may therefore employ the distinction under *all* circumstances. At the very least, the State must offer some substantial reason why the ability of a mentally competent, terminally ill patient to seek a physician's assistance in ending his or her suffering should depend upon the fortuity of whether he or she happens to be undergoing some course of treatment the discontinuation of which would cause death.

The fact that the State has traditionally had the power to prohibit assisted suicide cannot, by itself, justify infringing the liberty of respondents. This Court has consistently rejected the claim that constitutional liberty should be measured by reference to "the most specific level at which a relevant tradition protecting, or denying protection to, the asserted right can be identified." *Michael H. v. Gerald D.*, 491 U.S. 110, 127 n.6 (1989) (Scalia, J., joined by Rehnquist, C.J.). Instead, fidelity to the enduring constitutional

principles of this Court's prior cases requires that the liberty asserted be measured against those very principles. *See id.* at 132 (O'Connor, J., joined by Kennedy, J., concurring) (disagreeing with the narrow historical approach).

As this Court made clear in *Casey*, although the case for a woman's constitutional liberty to decide whether to have an abortion is a clearly convincing one, abortion nonetheless presents a difficult question because the State has a strong interest in the life of the fetus to be weighed against the woman's liberty. 505 U.S. at 871. By contrast, no interest of comparable dimension, and certainly no interest sufficient to justify an outright ban on the decisions at issue here, can be advanced by the State.

Nevertheless, the State has valid interests that justify careful regulation of the decision of a mentally competent, terminally ill patient to seek the assistance of a physician in carrying out his or her wishes about how to live life's final days. These interests include ensuring: that the patient is competent to make a decision; that the patient truly wishes to die; that the decision is not the product of coercion or undue pressure; that the patient has been made aware of alternatives that would ease his or her suffering; and that state recognition of the limited right sought here would not send a broader signal condoning suicide in general. Because careful regulations can be crafted to serve each of these legitimate interests (as well as others), the States' complete prohibitions must be deemed undue intrusions.

Carefully drawn regulations would also be more effective than the complete bans in furthering the State's legitimate ends. Notwithstanding laws like those at issue here, many physicians have in fact helped their patients to die;[2] yet "[t]here is no reported American case of criminal punishment being meted out to a doctor for helping a patient hasten his own death." *Compassion in Dying*, 79 F.3d at 811. Official criminalization assures that doctors who render aid in dying act in secrecy, or worse, that many patients seek out back-alley assistance from the unscrupulous. In this sense, current law in New York, Washington and most other States closely resembles the Dutch model of tacit approval of an illegal act. *See*

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[2] In a recent poll, 20% of the doctors surveyed admitted to having helped a patient to die. *See Poll Shows that 1 in 5 Internists has Helped a Patient Die*, Am. Med. News (Mar. 16, 1992) at 9.

Brief of the American Medical Association, *et al*, at 12-13 (No. 95-1858) (conceding that physician-assisted suicide is illegal but not prosecuted under Dutch law). The divergence between *de jure* and *de facto* rules of law that characterizes the Netherlands,[3] is an inappropriate model for the United States. Yet that is the regime that petitioners ask this Court to validate.

Finally, this Court should not reverse the decisions below in the vain hope of avoiding difficult line-drawing decisions. A decision to reverse would call for the drawing of seemingly purposeless lines and the creation of bizarre categories; for example, it would require the Court to explain the sense in which a doctor's violent removal of a large tube from a patient's esophagus is "inaction," while the patient's self-administration of a pill constitutes "action" by the doctor. *See* Brief for Petitioners Vacco and Pataki at 16-17 (No. 95-1858). Perhaps such seemingly arbitrary distinctions are permissible when all that is at stake is regulation of purely economic transactions, but not when the case involves intimate, personal, self-defining decisions -- as these cases undoubtedly do.

Argument

I. The Right of a Mentally Competent, Terminally Ill Adult to the Assistance of a Willing Physician in Carrying out a Decision About How to Live Life's Final Days is an Essential Aspect of the Liberty Protected by the Due Process Clause of the Fourteenth Amendment.

In *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), a majority of this Court reaffirmed "the essential holding" of *Roe v. Wade*, 410 U.S. 113 (1973). *Casey*, 505 U.S. at 846. In the course of explaining the basis for its decision, this Court made clear its continued adherence to the century-old principle that the Due Process Clause of the Fourteenth Amendment protects "all fundamental rights comprised within the term liberty," *Whitney v. California*, 274 U.S. 357, 373 (1927) (Brandeis, J., joined by

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[3] *See also* van Vliet, *The Uneasy Decriminalization: A Perspective on Dutch Drug Policy*, 18 Hofstra L. Rev. 717, 731 (1990) (noting that Dutch law makes possession of marijuana and hashish a crime, but other principles prevent enforcement of the prohibition).

Holmes, J., concurring), against undue state interference. *See Casey*, 505 U.S. at 846-47 (citing *Mugler v. Kansas*, 123 U.S. 623, 660-61 (1887), *Daniels v. Williams*, 474 U.S. 327, 331 (1986), and *Whitney*). The *Casey* Court reaffirmed that the Due Process Clause protects not only the rights expressly enumerated in the Bill of Rights, nor only "those practices, defined at the most specific level, that were protected against government interference by other rules of law when the Fourteenth Amendment was ratified." 505 U.S. at 847. "It is a promise of the Constitution that there is a realm of personal liberty which the government may not enter." *Id.* If this Court's liberty jurisprudence is to remain principled, that realm must include the decision of a mentally competent terminally ill adult to seek the assistance of a physician in carrying out his or her decision about how to live life's final days.

This Court's decision in *Casey* rested on more than just the principle of *stare decisis*. In the first portion of the *Casey* opinion, the Court unhesitatingly re-affirmed the existence of a constitutionally inviolable realm of individual conscience. To the extent that the *Casey* Court relied on the principle of *stare decisis* as a supplement to its basic reasoning, it did so for purposes of assessing the State's countervailing interest in fetal life. As the Court stated, "[t]he weight to be given [the] state interest [in fetal life], not the strength of the woman's interest, was the difficult question faced in *Roe*." 505 U.S. at 871.

The individual right claimed in the present cases falls squarely within the zone of liberty that the *Casey* Court reaffirmed without reliance upon the doctrine of *stare decisis*. The *Casey* majority reaffirmed the constitutional theory and practice guaranteeing protection for marriage, procreation, contraception, family relationships, child rearing, and education, 505 U.S. at 851, stating that

> [t]hese matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.

Id.

Let there be no mistake. These carefully chosen words from one of the century's most closely watched and hard-fought cases do not bear some mere accidental relation to the cases now before the Court. A terminally ill patient who needs the aid of a willing physician to end his or her suffering and to preserve what the patient believes to be his or her dignity faces a critical self-defining choice. To hold that such a decision is qualitatively less intimate, personal or central than decisions about where to send one's child to school, *see Pierce v. Society of Sisters*, 268 U.S. 510 (1925); *Meyer v. Nebraska*, 262 U.S. 390 (1923), would do irreparable damage to this Court's commitment to principled exposition of constitutional rights.

Even before *Casey's* careful reaffirmation of the constitutional basis for a protected zone of liberty, this Court made clear that end-of-life decisions implicate that protected zone. In *Cruzan v. Director, Missouri Dept. Of Health*, 497 U.S. 261 (1990), the Court began its analysis by recognizing that its prior cases support "[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment . . . ." *Id.* at 278. The majority opinion assumed for purposes of that case that a competent person has "a constitutionally protected right to refuse lifesaving hydration and nutrition." *Id.* Justice O'Connor -- who provided the critical fifth vote for the *Cruzan* majority -- did not merely assume such a right. Her concurrence depended on the understanding that "the liberty guaranteed by [the Due Process Clause] must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water." *Id.* at 289 (O'Connor, J. concurring). *Accord Washington v. Harper*, 494 U.S. 210, 221-22 (1990) (in the course of upholding state procedural scheme, stating "[w]e have no doubt that, in addition to the liberty interest created by the State's Policy, respondent possesses a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment").

To be sure, *Cruzan* used the language of "liberty interests" rather than "fundamental rights," 497 U.S. at 278, but then *Casey* similarly eschewed the fundamental rights label. More important than the precise doctrinal pigeonhole into which one places these cases is the fact that both *Casey* and *Cruzan* recognized that when

the State seeks to infringe basic liberties, it must show that doing so will advance interests of comparable weight. *See Casey*, 505 U.S. at 875-76; *Cruzan*, 497 U.S. at 279 ("'whether respondent's constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests.'") (quoting *Youngberg v. Romeo*, 457 U.S. 307, 321 (1982)).

Because of the exceedingly strong precedent supporting recognition of the right asserted here, petitioners resort to elaborate but unavailing argumentative gymnastics in their efforts to distinguish this Court's earlier decisions. They contend that the right recognized by a majority of this Court in *Cruzan* is only a right to refuse the imposition of unwanted medical treatment in the form of artificial life support or hydration and nutrition, rather than what they term *active* assistance. *See* Brief for Petitioners Vacco and Pataki at 16-17 (No. 95-1858). Petitioners offer two kinds of reasons for this distinction. First, they point to a variety of public policies which, they allege, are undermined by permitting so-called *active* death-hastening measures by doctors. Second, they contend that as an historical matter, the common law right given constitutional recognition in *Cruzan* does not extend beyond refusing or discontinuing medical treatment. Neither kind of reason provides a constitutional basis for the distinction proffered.

By invoking public policies that supposedly would be offended by permitting "active" death-hastening measures, petitioners and their amici seek to obscure the fact that *from the perspective of the individual*, the interest of a mentally competent, terminally ill adult in obtaining a physician's "active" aid in dying is identical to the interest in terminating life-support. This Court must therefore measure the public policies offered in support of the laws under review here *against* the right asserted by the plaintiffs, rather than double-counting these public policies by incorporating them *into* the definition of the right. If the State could show that its asserted policies justified overriding respondents' strong liberty interest, that would provide a constitutional basis for denying recognition to the right. However, "[w]hen the factors that provide the state's possible justifications for its regulation are automatically incorporated into the initial definition of a liberty, the fundamental nature of that liberty inevitably vanishes." Tribe & Dorf, On Reading the Constitution 107 (1991). As will be shown below, the proffered state interests cannot justify the blanket prohibitions before this

Court. Before addressing the state interests, however, this Court must examine the intended impact of the laws on the individuals subject to them. *Cf. Casey*, 505 U.S. at 894 ("The analysis does not end with the [persons burdened by the law]; it begins there. Legislation is measured for consistency with the Constitution by its impact on those whose conduct it affects.") That impact can only be described as enormous.

Viewing the relevant constitutional right recognized by this Court's prior cases as one of personal autonomy makes clear that the right encompasses the cases now before the Court. No volume of citations or lawyerly argument could refute the obvious fact that "few decisions are more personal, intimate or important than the decision to end one's life, especially when the reason for doing so is to avoid excessive and protracted pain." *Compassion in Dying v. Washington*, 79 F.3d 790, 813 (9th Cir. 1996) (en banc).

Indeed, the autonomy interest of a mentally competent, terminally ill patient in physician assistance in carrying out his or her decision about how to live life's final days would appear to be stronger than the right recognized by a majority of this Court in *Cruzan*. Respecting the wish of a person in a vegetative state to have life-sustaining medical treatment withdrawn invariably means respecting that person's *past* wishes -- typically formed at a time when he or she viewed the possibility of ending up in such a state as hypothetical. By contrast, a mentally competent, terminally ill patient acts with full knowledge of the reality and immediacy of the consequences. For the State to prohibit aid in dying for him or her is to interfere with the individual's autonomy in the here and now.

The right of a mentally competent terminally ill patient to physician assistance in carrying out his or her decision about how to live life's final days is also an exemplar of bodily integrity. Petitioners assert that the right to bodily integrity merely prohibits the State from imposing unwanted intrusions on the person. *See* Brief for the Petitioners at 30 (No. 96-110); Brief for Petitioners Vacco and Pataki at 9-11 (No. 95-1858). The act/omission distinction thus advanced is incoherent in the present cases, as a comparison with the abortion decisions reveals.

This Court has recognized the abortion right as grounded, *inter alia*, in bodily integrity. *See Casey*, 505 U.S. at 857. Yet the act of abortion constitutes affirmative intervention (by a physician, it should be noted) with a pregnant woman's "natural" state. Abortion

restrictions interfere with the right of bodily integrity because they have the effect of requiring the physical privations of pregnancy -- even though those privations occur as a natural result of the woman's condition. In the same way, prohibitions on physician assistance in the carrying out of end-of-life decisions interfere with the right of bodily integrity because they have the effect of requiring the physical and emotional privations of the illness from which the patient suffers -- even though those privations occur as a natural result of that illness. This Court's recognition that the abortion right is rooted in the right to bodily integrity thus inevitably implies that the right of a terminally ill patient to assistance in carrying out his or her decision about how to live life's final days is rooted in the same right to bodily integrity.[4]

Petitioners rely on a discredited narrow form of historical analysis in their efforts to carve out an ad hoc exception to this Court's liberty jurisprudence. They contend that the mixed historical pedigree of the constitutional right claimed here precludes its recognition. *See* Brief for the Petitioners at 21-25 (No. 96-110); Brief for Petitioners Vacco and Pataki at 11-13 (No. 95-1858). In its landmark decisions recognizing constitutional protection for liberty and equality, this Court has never considered itself bound by the kind of narrow historicism that petitioners and their amici contend should guide the decision in the present cases. The consistency of racial segregation with equal protection of the laws was widely assumed at the time of the adoption of the Fourteenth Amendment, *see, e.g.*, Hovenkamp, *The Cultural Crises of the Fuller Court*, 104 Yale L.J. 2309, 2338-40 (1995), yet that did not prevent a contrary conclusion in *Brown v. Board. of Educ.*, 347 U.S. 483 (1954). Similarly, as the *Casey* Court recognized, in *Loving v. Virginia*, 388 U.S. 1 (1967), eight Justices found that anti-miscegenation statutes violated the fundamental liberty to marry, notwithstanding the widespread acceptance of such prohibitions at the time of the adoption of the Due Process Clause and for a long

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[4] The United States attempts to distinguish *Roe* and *Casey* on the ground that abortion prohibitions produce the responsibilities of parenthood as well as the suffering associated with pregnancy. *See* Brief for the United States as Amicus Curiae Supporting Petitioners at 16-17 (No. 96-110). But that factor has no independent weight, for if it did, then a man would have a constitutional liberty in forcing his mate to have an abortion, and biological parents would have a similar liberty to commit infanticide.

time thereafter. *See Casey*, 505 U.S. at 847-48 (citing *Loving*, 388 U.S. at 12).[5]

Of perhaps greatest significance, the *Cruzan* Court itself did not inquire into whether the common law traditionally protected a specific right to the removal of nutrition and hydration, nor did it even accord significant weight to the contemporary treatment by state legislatures of that precise act. After canvassing the evolving approach in the state courts, this Court concluded in broad terms:

> As these cases demonstrate, the common-law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment. Beyond that, these cases demonstrate both similarity and diversity in their approaches to decision of what all agree is a perplexing question with unusually strong moral and ethical overtones.

497 U.S. at 277. The Court then exercised its own judgment in assuming that this right included rejecting nutrition and hydration. *See id.* at 279.

Justice O'Connor's crucial concurring opinion in *Cruzan* used

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[5] Petitioners in No. 96-110 attempt to distinguish *Loving* by noting that "'[t]he freedom to marry has long been recognized as one of the vital personal rights essential to the orderly pursuit of happiness,' even though the right to inter-racial marriage has no similar historical pedigree. Brief for the Petitioners at 22 (quoting *Loving*, 388 U.S. at 12). But this point merely underscores the flaw in petitioners' basic mode of analysis. The *Loving* Court found it sufficient that the very specific right to inter-racial marriage, although itself not "deeply rooted in this nation's history and tradition," *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977), was an instance of the broader historical tradition affording protection to marriage and other intimate associations. So too here, although the very narrow right of a mentally competent, terminally ill patient to the assistance of a willing physician in carrying out a decision about the end of life has not been the subject of positive legal protection, it is an instance of the broader historical and legal tradition affording protection to important intimate and personal decisions. Petitioners are surely right that "[t]he degree of specificity with which the asserted right is described is important and may be determinative of the extent to which the claim of constitutional protection is recognized." Brief for the Petitioners at 19 (No. 96-110) (citing Tribe and Dorf, *Levels of Generality in the Definition of Rights*, 57 U. Chi. L. Rev. 1057 (1990)). Yet they offer no justification for selecting the extremely narrow level at which they focus. By contrast, amici respectfully submit that we have focused at the proper level because, from the perspective of the individual, the right respondents claim commands the same or greater respect as the right recognized in *Cruzan* and this Court's other cases in this area.

the same mode of analysis. After locating a broad right to refuse medical treatment in the Court's prior decisions, Justice O'Connor concluded: "The State's artificial provision of nutrition and hydration implicates identical concerns. Artificial feeding cannot readily be distinguished from other forms of medical treatment." *Id.* at 288 (O'Connor, J., concurring). Thus, in the decision of this Court that most closely resembles the present cases, the Court did not employ the narrow historical methodology that petitioners and their amici advocate. Petitioners and their amici seek to replace this Court's tradition of reasoned elaboration with the oft-rejected view that this Court should only recognize the most specific rights protected by an historical tradition. *See Michael H. v. Gerald D.*, 491 U.S. 110, 132 (1989) (O'Connor, J., joined by Kennedy, J., concurring) (disagreeing with the narrow historical approach).

Similarly unavailing are the efforts of petitioners and their amici to invoke contemporary state practice as a basis for denying respondents' claim of constitutional right. It is that very practice that is under challenge here. Moreover, as the en banc panel of the Court of Appeals for the Ninth Circuit noted below, there is considerable public support for a carefully regulated right of mentally competent terminally ill patients to physician assistance in carrying out their decisions about how to live life's final days. *Compassion in Dying*, 79 F.3d at 810 (citing public opinion polls and the results of the 1994 Oregon referendum). At the same time, even where such assistance is prohibited, the urgency of reform efforts is dampened by the nearly complete lack of enforcement.[6]

Standing alone, current social attitudes and trends in the positive law of the States might not be sufficient to establish a terminally ill patient's constitutional right to autonomy in decisions about how to live life's final days. But these trends and attitudes do not stand alone. Recognition for the right rests on the solid foundation of principled application of decisions this Court has already rendered.

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[6] Apparently conceding the point, petitioners' amici grasp at straws by asserting that "the States do enforce their assisted suicide laws." Brief Amicus Curiae on Behalf of Members of the New York and Washington State Legislatures in Support of Petitioners at 21. This general proposition, however, has no bearing on the specific issue now before the Court, as petitioners' amici cite no case involving a doctor assisting a terminally ill patient. *See id.* at 21 n.15 (citing, *inter alia*, two cases involving teenage suicide pacts, *see In Re Joseph G.*, 667 P.2d 1176 (Cal. 1983); *State v. Bauer*, 471 N.W.2d 363 (Minn. App. 1991)).

At the very least, current social attitudes and trends in state positive law do nothing to undermine the case for the constitutional right advanced here. Indeed, they appear to strengthen that case.

If this Court's liberty doctrine is to remain a jurisprudence of principle and not a mere assortment of ad hoc judgments, it must recognize that the right of a mentally competent terminally ill patient to seek assistance in carrying out his or her decision about how to live life's final days lies at the very core of the constitutionally protected personal autonomy and bodily integrity that this Court has long recognized. Thus, whatever arguments petitioners and their amici advance to distinguish that right must, at the outset, be of sufficient weight to overcome an individual interest of the highest order. As will be shown below, although the State has legitimate regulatory interests in this area, none of them remotely justifies an absolute ban.

II. The Equal Protection Clause of the Fourteenth Amendment Provides an Alternative Basis for Affirming the Rulings Below, but Whether Viewed as a Question of Due Process Liberty or Equal Protection, the Central Question in these Cases is Whether the States have Offered a Sufficient Justification for Overriding Personal Autonomy.

Hornbooks of constitutional law state that laws challenged under the Fourteenth Amendment as infringing rights protected by the Due Process or Equal Protection Clause will be subject to heightened scrutiny if they infringe fundamental rights. *See, e.g.*, Nowak and Rotunda, Constitutional Law § 11.7, at 399 (5th ed. 1995). Otherwise, legislation not employing illicit classifications is subject only to the deferential rational basis test. *See id.*, § 11.4, at 383. Although this framework has the virtue of simplicity, it has two important limitations. First, its on/off character requires the courts to draw somewhat arbitrary lines between fundamental rights and lesser interests. Second, it seems to require the courts to treat all laws affecting fundamental rights with equal suspicion, even though they might serve quite different purposes. For these reasons, it is fair to say that this Court's Fourteenth Amendment jurisprudence was never quite so simple as the hornbooks would suggest. *See Zablocki v. Redhail*, 434 U.S. 374, 386 (1978). *Cf. San Antonio Indep. School Dist. v. Rodriguez*, 411 U.S. 1, 98-110

(1973) (Marshall, J., dissenting); Note: *Justice Stevens' Equal Protection Jurisprudence*, 100 Harv. L. Rev. 1146 (1987).

In *Casey*, the joint opinion of Justices O'Connor, Kennedy, and Souter announced that abortion regulations would be judged according to an undue burden test, under which laws with the purpose or effect of emplacing substantial obstacles in the way of a decision to have an abortion would be held invalid. 505 U.S. at 877. Whether the undue burden test reflects a judgment as to how the strict scrutiny standard ought to apply in the abortion context, *see* Dorf, *Facial Challenges to State and Federal Statutes*, 46 Stan. L. Rev. 235, 272 n.153 (1994), or whether it represents a more general approach to classifying various kinds of burdens on individual rights, *see* Dorf, *Incidental Burdens on Fundamental Rights*, 109 Harv. L. Rev. 1175, 1219-32 (1996), is perhaps an interesting academic question. The import of *Casey* for the present cases, however, is clear: recognition of the right of a mentally competent, terminal patient to seek the assistance of a willing physician in carrying out his or her decision about how to live life's final days does not automatically lead to the invalidation of all laws regulating that decision. Rather, the Court must undertake a careful examination of the ends and means of state regulation.

In its decision below, the Court of Appeals for the Second Circuit believed that it was constrained not to recognize "new" constitutional rights under the Due Process Clause. *See Quill*, 80 F.3d at 724-25. That reluctance was based in part on an overly broad reading of *Bowers v. Hardwick*, 478 U.S. 186 (1986), *see Quill*, 80 F.3d at 724-25, a case whose core holding has been eroded by this Court's decision in *Romer v. Evans*, 116 S. Ct. 1620 (1996), and whose methodology has not been in evidence for quite some time, even in Due Process Liberty cases. The lead opinion in *Casey*, for example, does not even cite *Hardwick*. What remains of *Hardwick* is perhaps a cautionary note with which no sensible student of constitutional law could disagree – that the Court should tread lightly in defining zones of liberty under the Due Process Clause. Affirming the judgments below would not in any way contravene this caution.[7]

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[7] The Second Circuit also believed itself constrained to avoid a ruling under the Due Process Clause because it is a lower court. *See Quill*, 80 F.2d at 725 ("Our position in the judicial hierarchy constrains us to be even more

More fundamentally, the Second Circuit's own analysis of the Equal Protection issue belies any concern that respondents seek a "new" liberty. The central basis for the Second Circuit's ruling is that the right of a mentally competent, terminally ill adult to seek the assistance of a physician in carrying out his or her decision about how to live life's final days cannot be rationally distinguished from the right of a similarly situated patient to refuse life-saving medical treatment. *See id.* at 725-31. Whether the Court recognizes this linkage as a matter of Due Process or Equal Protection is of much less significance than that the Court recognize its obligation to apply its precedents in a principled manner. *See Bolling v. Sharpe*, 347 U.S. 497, 499-500 (1954) (holding that the Fifth Amendment Due Process Clause prohibits arbitrary classifications, a category largely coextensive with those prohibited by the Fourteenth Amendment's Equal Protection Clause). Distinctions that bear on so intimate and central a choice as the one at issue here must, at the very least, be supported by more than the State's conclusory assertion that it wishes to extend protection to the choice in some circumstances, but not in others.

The Court need not, and probably should not, adopt a doctrinal approach to be used to test all state regulations of, and distinctions regarding, the right of a mentally competent, terminally ill adult to seek the assistance of a physician in carrying out his or her decision about how to live life's final days. To decide this case it is sufficient to ask the States to come forward with some substantial justification for the complete bans at issue. As will be shown in the next section, the States fail this minimal requirement.

Nevertheless, should this Court decide to announce a doctrinal framework applicable to future cases, amici respectfully suggest that the undue burden test elaborated by the joint opinion in *Casey* provides the appropriate framework. That test properly recognizes that not all regulations governing the exercise of a right infringe that right. *See Casey*, 505 U.S. at 874-75; *See also Zablocki*, 434 U.S. at 386 (denying that "every state regulation which relates in any way to the incidents of or prerequisites for marriage must be subjected to rigorous scrutiny.") The undue burden standard of *Casey* requires that only laws with the purpose or effect of placing a substantial

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reluctant than the Court to undertake an expansive approach in this unchartered area."). That constraint, by definition, does not apply to this Court.

obstacle in the path of the right's exercise should be deemed infringements of that right. Whether this standard applies to *all* constitutional rights is a puzzle well beyond the scope of this case. For present purposes, it is sufficient to note that the State has related interests in regulating decisions about abortion and the end of life, so that it would be appropriate to apply the undue burden test here.[8]

Of course, a flat ban on patient choice quite obviously has both the purpose and effect of placing a substantial -- indeed an insurmountable -- obstacle in the path of the exercise of the right asserted here. Thus, the only real question is whether petitioners can come forward with a justification for this severe burden. As will be shown in the next section, they cannot. Whether the Court applies traditional heightened scrutiny or a standard more akin to a balancing test, the measures at issue here simply cannot be sustained.

III. No State Interest Justifies a Blanket Prohibition on a Mentally Competent, Terminally Ill Patient's Exercise of the Right to the Assistance of a Willing Physician in Carrying out his or her Decision About how to Live Life's Final Days.

Recognizing the constitutional dimension of a mentally competent patient's decision to seek a physician's assistance in carrying out his or her decision about how to live life's final days does not, of course, preclude all regulations designed to further the State's important countervailing interests. As respondents have conceded throughout the proceedings below, and as both the Courts of Appeals for the Second and Ninth Circuits recognized, the State does have important regulatory interests. Nevertheless, the mere recitation of state interests cannot be permitted to displace constitutional analysis. In the case of abortion, after all, the State validly asserts an interest in what many people consider to be innocent human life; yet in *Casey*, a majority of this Court understood that even that exceptionally important state interest does

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[8] Thus, there is no reason to conclude that affirming the results below would mean that all "state supervision and regulation in this area will be subject to exacting judicial review." Brief of Amicus Curiae State of Oregon in Support of Petitioners at 1 (No. 96-110).

not invariably override the liberty protected by the Due Process Clause.

The state interests most frequently cited by petitioners and their amici in support of the laws challenged here include: (1) protection and preservation of life, *simpliciter*; (2) prevention of suicide; (3) prevention of coercion and undue influence; (4) prevention of the devaluation of the lives of the handicapped and other disadvantaged members of society; and (5) maintaining the ethical integrity of the medical profession. For completeness, it will be shown below that each of these interests can be readily accommodated by measures falling well short of the outright bans under review here. The Court should not, however, miss the forest for the trees. None of the state interests advanced here weigh as heavily as the interest in innocent human life at stake in the abortion context.[9] If, as the Court has correctly held, that interest cannot justify an outright ban on all abortions, surely the less weighty state interests advanced here cannot justify the outright bans on the exercise of a mentally competent, terminally ill adult's right to seek the assistance of a physician in carrying out his or her own decision about how to live life's final days.

[9] The fact that a fetus is not a person within the meaning of the Fourteenth Amendment, *see Roe v. Wade*, 410 U.S. 113, 156-59 (1973), does not mean that the State has no interest in protecting the fetus. To the contrary, the State has a very strong interest in fetal life, even before viability, *see Casey*, 505 U.S. at 872, but even that very strong interest is insufficient to override the woman's liberty. Petitioners' amici would infer from *Roe*'s conclusion about the constitutional status of the fetus the proposition that in order for respondents to prevail in this Court, they must show that terminally ill patients are not persons within the meaning of the Fourteenth Amendment. *See* Brief Amicus Curiae on Behalf of Members of the New York and Washington State Legislatures in Support of Petitioners at 7-8. Yet the very fact that terminally ill patients *are* persons within the meaning of the Fourteenth Amendment gives rise to their rights under the Due Process and Equal Protection Clauses. For the State to override those claims it must proffer an interest *to be weighed against them*.

A. The State's Interest in Protection and Preservation of Life, *Simpliciter*, Does Not Justify an Outright Ban on Physicians Rendering Assistance to a Mentally Competent, Terminally Ill Patient in Carrying out his or her Decision About how to Live Life's Final Days.

This Court's decision in *Cruzan* precludes a conclusion that the State's abstract interest in life can outweigh a patient's right of autonomy in end-of-life decisions. In *Cruzan*, this Court appeared to divide over whether the State may assert a legitimate interest in life, apart from -- and in opposition to -- the wishes of the person whose life is at stake. Speaking for three members of the Court, Justice Brennan averred that "the State has no legitimate general interest in someone's life, completely abstracted from the interest of the person living that life, that could outweigh the person's choice to avoid medical treatment." 497 U.S. at 313 (Brennan, J., dissenting). A fourth member, Justice Stevens, agreed. *See id.* at 331 (Stevens, J., dissenting) (finding "the State's abstract, undifferentiated interest in the preservation of life" an inadequate basis for overriding patient choice). The majority opinion of Chief Justice Rehnquist stated that "a State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual." *Id.* at 282 (opinion of the Court).

Although amici would respectfully suggest that the *Cruzan* dissenters' view is to be preferred,[10] even the view espoused by the Chief Justice in *Cruzan* requires that the individual right be given greater weight than the State's abstract interest in life. The *Cruzan* Court addressed a question that arises amid uncertainty. The Court faced the question of how to balance societal interests against individual choice when the result of individual choice is unknown. The Court determined that, in the light of such uncertainty, the State's abstract interest in life, combined with other legitimate state interests, can justify a procedural mechanism requiring clear and

[10] *See* Dworkin, Freedom's Law: The Moral Reading of the American Constitution 140-43 (1996) (arguing that interests that are detached from any person's well-being ought not be permitted to override an actual person's concrete wishes on matters of self-defining religious or spiritual importance).

convincing evidence of patient intent. Nevertheless, the fact that the Court assumed that a competent patient has a constitutional right to refuse life-saving medical treatment -- a point that was a necessary condition for Justice O'Connor's crucial concurrence -- means that even the *Cruzan* majority assumed that the State's abstract interest in life cannot justify overriding patient choice when that choice is clear.

To say that a competent patient would have the right to refuse life-saving medical treatment is to say that *no state interest* is sufficiently strong to overcome that right as a categorical matter. Thus, whether one deems the State's abstract interest in life an illegitimate basis for regulation -- as the *Cruzan* dissenters did -- or as a legitimate interest that justifies some state regulation -- as the Chief Justice's opinion in *Cruzan* did -- there is no basis for concluding that the State's abstract interest in life can justify entirely overriding patient choice. The interest simply does not outweigh the individual liberty at stake.

The premise that the State's abstract interest in life does not justify overriding individual autonomy does not in any way depend upon the supposed distinction between withdrawal of medical treatment and the prescription of life-ending medication. Whatever the merits of that distinction for other purposes, the State's abstract interest in life is identical in both cases. In either case, the state interest is in the preservation of life. Any measure that hastens the end of life, whether characterized as *action* or *inaction*, poses a threat to the State's abstract interest in life. Thus, the attempts by petitioners and their amici to characterize the right at stake in this case as involving "active" assistance simply have no relevance to the question whether the State's abstract interest in life overrides patient autonomy. That question was resolved in the negative by the course of reasoning in *Cruzan,* and the resolution there fully applies here.

This is not to say, however, that the State is powerless to take measures to further its abstract interest in life. As the joint opinion of Justices O'Connor, Kennedy, and Souter stated in *Casey:*

> Though the woman has a right to choose to terminate or continue her pregnancy before viability, it does not at all follow that the State is prohibited from taking steps to ensure that this choice is thoughtful and informed. Even in the earliest stages of pregnancy, the State may enact rules

> and regulations designed to encourage her to know that there are philosophic and social arguments of great weight that can be brought to bear in favor of continuing the pregnancy to full term and that there are procedures and institutions to allow adoption of unwanted children as well as a certain degree of state assistance if the mother chooses to raise the child herself.

505 U.S. at 872. So too may the State seek to ensure that a decision so momentous and irreversible as to forego even a short period at the end of life is a fully informed one. To this end, reasonable state laws that provide a framework in which this decision is made, should be upheld. Indeed, properly understood, *Cruzan's* approval of a heightened evidentiary threshold safeguards just such an interest -- ensuring that patient choice is in fact respected.

In the context of the present cases, the State can pursue its abstract interest in life by measures short of a total ban on patient choice. Proposals recently introduced in the legislatures in many States provide a variety of permissible means of addressing the State's legitimate concern that the patient himself or herself has given adequate attention to the sacredness of all life, and has considered the available alternatives. These proposals, which are summarized in Appendix A to this brief, include requirements that two financially independent physicians certify the patient's mental competence, that the patient make repeated statements of his or her wish to end life, that the patient be provided with information about treatment options, including palliative care, as well as other safeguards. This Court need not and should not hold that any of these particular provisions is constitutionally required to recognize that by removing *all choice* from patients, the New York and Washington laws go too far.

B. The State's Interest in Prevention of Suicide Does Not Justify an Outright Ban on Physicians Rendering Assistance to a Mentally Competent, Terminally Ill Patient in Carrying out his or her Decision About how to Live Life's Final Days.

Perhaps none of the arguments presented by petitioners and their amici has the same emotional appeal as the contention that affirming the decisions below would set the Court sliding down the

slippery slope to sanctioning suicide as a constitutional right. The claim is specious. Principles of judicial restraint counsel the Court to craft a narrow ruling in this case, one that addresses the facts before it, while leaving some line-drawing questions for another day.[11] Furthermore, even if the Court decides to tackle such questions here, affirming the judgments below in no way entails recognizing a general constitutional right to suicide. Indeed, examination of the state interest that justifies preventing suicide strengthens the conclusion that the cases before the Court present a very different question.

Apart from the State's abstract interest in life, the State's principal interest in preventing suicide is to preserve the actual life of persons who would otherwise commit suicide. The State may assume that a person who has not been diagnosed with a terminal illness will derive fulfillment from years of future life -- even if he or she does not presently realize this to be so. In preventing suicide by persons who are not terminally ill, the State seeks to protect the future self against the potentially rash judgment of the present self.

In contrast, a patient suffering from a terminal illness has no expectation of sustained future life. As a result, the State's interest in protecting the future self against the decision of the present self is greatly diminished. It is frankly grotesque for the State to justify overriding the patient's will on the ground that the patient would benefit from several weeks or months of physical deterioration or mental decomposition. The difference between preventing suicide generally and preventing a terminally ill patient from receiving a willing physician's aid in dying is the difference between a tolerable degree of paternalism in the interest of a person's enjoyment of life and what, from the perspective of the patient, can only be described as sadism.

"Liberty must not be extinguished for want of a line that is clear." *Casey,* 505 U.S. at 869. It certainly should not be extinguished because of imagined ambiguities that lie down a road

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[11] It is ironic that petitioners and their amici invoke the specter of judicial activism, while at the same time urging that the Court must issue a broad, categorical ruling. The charge of activism has been most deserved when the Court has reached out to decide questions not squarely before the Court. *See* Ginsburg, *Speaking in a Judicial Voice,* 67 N.Y.U. L. Rev. 1185 (1992). It is plain that in this case, petitioners and their amici seek a broad, categorical ruling, while respondents and their amici urge the Court to proceed with caution.

upon which this Court need never tread. The general state interest in preventing suicide has no bearing on the present cases.

C. The State's Interest in Preventing Coercion or Undue Influence Does Not Justify an Outright Ban on Physicians Rendering Assistance to a Mentally Competent Terminally Ill Patient in Carrying out his or her Decision About how to Live Life's Final Days.

The State has a strong interest in preventing coercion or undue influence from being brought to bear on patients facing end-of-life decisions. Such pressure might come from health care providers seeking to redirect scarce medical resources and save on care costs or from family members who wish to spare themselves the emotional and financial drain of a loved one's protracted period of dying. These pressures justify state regulation to ensure that end-of-life decisions are made without coercion or undue influence.

Nevertheless, the risk of coercion is that a patient will be forced or pressured to choose a path that he or she would rather not choose. By seeking to enforce blanket prohibitions, petitioners would guarantee that in a large number of cases all choice is denied. Petitioners' proposed solution to the risk of coerced decisions -- removal of all decision making autonomy from the patient -- exacerbates the very problem it purports to solve.

The risks of coercion and undue influence are at least as great when a patient seeks to discontinue lifesaving medical care as when a patient seeks so-called *affirmative* aid. The same health professionals and family members face the same set of incentives when the patient's decision involves whether to discontinue medical treatment as they do when the patient's decision involves whether to seek a physician's aid in carrying out his or her decision to end life by other means.[12] Yet, as Petitioners concede, neither New

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[12] For example, the United States asserts that "[w]hen the choice is between suicide and an expensive and prolonged course of treatment, physicians may feel pressured to suggest the former." Brief for the United States as amicus curiae Supporting Petitioners at 24 (No. 96-110). Yet it is precisely such treatment that the United States and petitioners acknowledge that patients have a right to refuse, even when death will result. Similarly perplexing is the American Medical Association's concern that patients will seek aid in dying because they suffer from depression, *see* Brief of the American Medical Association, *et al.* at

York, Washington, nor any other State finds that these risks justify a ban on the discontinuation of lifesaving medical care, *see* Brief for the Petitioners at 12 (No. 96-110); Brief for Petitioners Vacco and Pataki at 11 (No. 95-1858) -- nor could they so find, given this Court's understanding in *Cruzan* that the risks of error must be carefully balanced.

Indeed, many States, including New York and Washington, permit the appointment of a surrogate to make life and death treatment decisions in the event the patient becomes incapacitated. *See* N.Y. Pub. Health Law §§ 2980-94 (McKinney 1993); Wash. Rev. Code Ann. § 11.94.010(3) (West Supp. 1996). When a patient has become incapacitated, the risk of a decision that reflects the interests of the surrogate or health care provider rather than the patient is at a maximum. In contrast, a mentally competent, terminally ill patient who seeks the assistance of a willing physician in carrying out his or her decision about how to live life's final days is in control of the decision making process in a way that cannot be true when a surrogate is required. By nonetheless allowing for surrogate decisionmaking in the event of incapacitation, the States recognize that the paramount interest in end-of-life decisions is ensuring that the patient's true wishes be carried out -- even when the risks of decisions based on other factors are substantially greater than when a mentally competent, terminally ill patient makes the ultimate decision.

Therefore, anecdotal evidence that permitting physicians to render aid in dying would lead doctors to pressure patients to end their lives, *see* Hendin, Seduced by Death: Doctors, Patients, and the Dutch Cure (1996), proves only that the States must have the authority to enact safeguards to ensure that a patient's decision is not the product of undue pressure. However, the state interest in preventing doctors from prescribing lethal medication to a patient who wishes to remain alive no more justifies a flat ban on such aid in dying than the identical state interest in preventing doctors from discontinuing lifesaving medical treatment against a patient's will would justify a blanket prohibition of patients' ability to discontinue such treatment.

In this context, regulation, as opposed to prohibition, is quite

8-9 (No. 95-1858), given that patients are equally likely to refuse, or seek the withdrawal of, lifesaving treatment because they suffer from depression.

practical. As the eponymous respondent in No. 95-1858, Dr. Timothy Quill, has himself noted, the patient's right to make unencumbered decisions to die with dignity can be insulated from coercive pressure by requiring multiple requests, a healthy doctor-patient relationship, secondary consultation with another physician and clear documentation of the decision process. *See* Quill, *Care of the Hopelessly Ill*, 327 New Eng. J. Med. 1380 (1992). In addition, palliative care groups could be required to review patient requests and physician decisions to minimize the risk of abuse while ensuring access to the procedure when it is medically and ethically justified. Such a review program is particularly well-equipped to counter the threat of coercion by family members, doctors, or health maintenance organizations, because palliative-care review focuses on the condition and desires of the patient. *See* Miller, *et al.*, *Regulating Physician Assisted Death*, 331 New. Eng. J. Med. 119 (1994). *See also* Appendix A.

Thus the concern of petitioners and their amici that patients will seek a physician's aid in dying without exploring palliative care options is misplaced.[13] If anything, recognition of the right asserted here will require States to adopt more precise regulatory mechanisms, with the likely result that many patients who legally seek aid in dying will be required to contemplate palliative care options that, under existing law, they would not have considered.

The State may enact a wide variety of reasonable measures designed to ensure that the patient's decision reflects his or her will, free of coercion or undue influence. What the State may not do is deny all patient choice in the name of safeguarding unfettered choice. Yet that is precisely what the New York and Washington laws do.

[13] In their focus on palliative care, petitioners and their amici obscure the fact that not all suffering experienced by terminally ill patients takes the form of physical pain. For many patients, the greater horror is the disintegration of their physical and mental capacities. To the extent that palliative care relies on sedation, it merely exacerbates the problem.

D. The State's Interest in Protecting the Handicapped and Other Disadvantaged Members of Society Does Not Justify an Outright Ban on Physicians Rendering Assistance to a Mentally Competent, Terminally Ill Patient in Carrying out his or her Decision About how to Live Life's Final Days.

Opponents of the right claimed here assert that the State has an interest in avoiding measures that will have the cumulative impact of devaluing the lives of persons with disabilities. *See, e.g.,* Brief Amici Curiae of the National Legal Center for the Medically Dependent & Disabled, Inc. at 9-11; Brief Amicus Curiae of the Catholic Medical Association at 15-16. In its strongest form, the argument goes as follows: in order to avoid enshrining a general right to suicide, the State must designate some conditions as qualifying persons for a right to physician assistance in ending life; the State thereby impliedly asserts that the quality and value of life for persons in the designated conditions is lower than for other persons; to avoid sending this message of inferiority, the State should avoid drawing such lines.

Whatever the force of the above argument, it is simply irrelevant to the cases now before the Court. The patients here (and the doctors who wish to assist them) all suffer from terminal illnesses. As noted above, the distinction between such patients and persons who do not suffer from a terminal illness has nothing to do with an assessment by the State (or a court) of the value of life. The point is that with death inevitable and imminent, the State's general interest in preventing suicide -- the interest in protecting a future self against the possibly rash judgment of the present self -- is greatly diminished. The Court need not and should not say in these cases that the State has some obligation to allow physician-assisted suicide for persons with some set of disabilities but not for other persons. The Court can and should affirm the rulings below without in any way implying such an obligation.

To the extent that petitioners also assert that persons with handicaps and other disadvantages deserve protection from undue pressure, of course we agree. The State has a strong interest in ensuring that the vulnerable are not pressured to seek physician assistance in ending life, just as it has a strong interest in ensuring that the vulnerable are not denied equal access to the right asserted here. *See Compassion in Dying*, 79 F.3d at 825 (observing that the

poor and minorities are more often under pressure *not to* exercise their rights, as in the case of abortion). For this reason, we support efforts to enact legislation that would ensure that mentally competent, terminally ill patients who seek a physician's aid in dying are not acting in response to financial or other undue pressure. The same measures that would limit the opportunities for coercion in general will provide protection for persons who are members of disadvantaged groups. *See* Appendix A.

E. The State's Interest in Maintaining the Ethical Integrity of the Medical Profession Does Not Justify an Outright Ban on Physicians Rendering Assistance to Mentally Competent Terminally Ill Patients in Carrying out Decisions About how to Live Life's Final Days.

In order to protect constitutional rights, this Court has not hesitated to strike down legislation that reflects a professional organization's view of the limits of acceptable behavior. *See, e.g., Bates v. State Bar*, 433 U.S. 350 (1977) (invalidating ban on attorney advertising). *Cf. Florida Bar v. Went For It, Inc.*, 115 S. Ct. 2371 (1995) (applying commercial speech test to state bar regulations). Thus, although the American Medical Association officially disapproved of abortion as late as 1967, *see Roe*, 410 U.S. at 142-43 (citing Proceedings of the AMA House of Delegates 40-51 (June 1967)), the *Roe* Court nonetheless recognized such a right. The fact that some or many members of a profession deem a particular practice inconsistent with their professional role is a valid reason why no professional should be *forced* to engage in that practice. It is not a reason why a professional who is willing to depart from the official position should be *prohibited* from following his or her conscience.

Accordingly, the objection that state-sanctioned physician aid in dying would convert doctors from healers into killers has no greater purchase here than does the parallel argument in the abortion context. No doctor should be required to render aid in dying to a patient who seeks the doctor's assistance, just as no doctor is required by *Roe* and *Casey* to perform an abortion.

The question whether a particular practice such as aid in dying is inconsistent with a doctor's professional role cannot be answered, as petitioners and their amici suggest, by definitional fiat. Here, the

willingness of a professional to assist the individual will facilitate the exercise of constitutional liberty. Under these circumstances, a professional organization cannot declare, as *ipse dixit*, that such assistance contravenes the professional role, and ask the Court to defer blindly to its unilateral judgment.

In fact, despite laws like those challenged here, and despite the reflexive opposition of the American Medical Association, opinion polls consistently show substantial support among doctors for the provision of aid in dying to mentally competent, terminally ill patients.[14] These doctors evidently understand the practice as consistent with their professional role. They believe that to deny the only form of relief they can render their terminally ill patients is an act of cruelty.

The argument that permitting doctors to perform abortions would lead to a devaluation of human life by the medical community was rejected by the *Roe* Court. There is no empirical support for the predicted devaluation. Indeed, the very fact that the American Medical Association appears now before the Court, with its professional integrity intact after 23 years of legalized abortion, making the very same argument rejected in *Roe*, merely underscores the flaw in the argument. The Association was wrong in its pre-*Roe* position, and it is wrong now.[15] Individual doctors can be trusted,

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[14]Jerald Bachman found that 54% of physicians favored legislation legalizing physician assistance for terminally ill, mentally competent adults. Bachman, *Assisted Suicide and Active Euthanasia in Michigan*, 331 New Eng. J. Med. 812 (1994). Jonathan Cohen polled 938 doctors in Washington and found that 54% supported physician assistance under certain carefully limited circumstances. Cohen, *Attitudes Toward Assisted Suicide and Euthanasia Among Physicians in Washington State*, 331 New Eng. J. Med. 89 (1994). A poll of 740 Wisconsin doctors showed 42% supported a right of physician assistance for competent adults faced with severe illness and little chance of recovery. 28% of the Wisconsin sample said they would be willing to perform the procedure, Shapiro, *Willingness to Perform Euthanasia*, 154 Archives Internal Med. 575 (Mar. 14, 1994) (WL, AMA-JNLS database) (1994).

[15] The Association is also wrong in its assertion that regulations of the sort currently under consideration by the state legislatures would work an "unprecedented intrusion into the physician-patient relationship" and "would be fundamentally inconsistent with the private nature of health care treatment." Brief of the American Medical Association, *et al* at 17 (No. 96-110). The rise of managed care has already transformed the physician-patient relationship from the model the Association portrays. *See* Shaw, Letter: *Economics and the Examination Room: An Incident*, 347 Lancet 124-25 (1996).

subject to careful but reasonable regulation, to prescribe lethal medication to mentally competent, terminally ill patients who need assistance in carrying out their decisions about how to live life's final days.

IV. Affirming the Judgments Below Would Give Proper Recognition to the Principle that this Court Shares Responsibility with the State and Federal Legislatures for Striking a Balance Between Constitutional Rights and Government Regulation.

Petitioners and their amici attempt to tantalize this Court with the fool's gold of a decision avoided. Their argument takes the form of the question-begging trope that the Constitution is silent on the issue posed by these cases. The argument is bad in itself. Of course the text of the Constitution does not expressly mention aid in dying, any more than it expressly refers to flag-burning, discrimination on the basis of skin color, or a host of other practices that fall within the Constitution's general language. *See McCulloch v. Maryland*, 17 U.S. (4 Wheat.) 316, 407 (1819) (noting that the Constitution does not "partake of the prolixity of a legal code," and thus "only its great outlines should be marked").

Beyond its fundamental misapprehension of the nature of constitutional interpretation, the argument advanced by petitioners and their amici paints a vastly oversimplified picture of the reality the Court would face were it to reverse the judgments below. The Court would have to distinguish its commitment to even a very narrow version of the principle announced in *Cruzan*, namely that the Constitution affords protection to the right to refuse unwanted bodily intrusions, including means of respiration, nutrition and hydration. *See Cruzan*, 497 U.S. at 289 (O'Connor, J., concurring) ("the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water.").

To do otherwise, that is, to renounce the premise shared by eight Justices in *Cruzan* and expressly adopted by five Justices, would be to do irreparable harm to this Court's Due Process Liberty

jurisprudence. In *Casey*, this Court made clear that the right to choose an abortion free of undue government coercion encompasses the right to choose *not* to have an abortion free of government coercion. The Court stated that "*Roe* has been sensibly relied upon to counter any . . . suggestions" to the contrary. *Casey*, 505 U.S. at 859. In support of this proposition, the *Casey* Court cited a prominent decision of the New Jersey Supreme Court recognizing a right to refuse medical treatment. *See id.* (citing *In re Quinlan*, 70 N.J. 10, *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976)).

Therefore, in order to maintain even the semblance of principled adjudication, a decision reversing the judgments below would have to explain why a right to refuse medical treatment receives constitutional protection but a right to the assistance of a willing physician in hastening death by other means does not. The Court would then be faced with the daunting task of defining the limits of the right to refuse treatment.

Suppose, for example, that a State were to forbid the withdrawal of a feeding tube or respirator in cases in which the patient initially consented to its insertion. Such withdrawal is an active measure that brings about death. Could the State decide that it is therefore not encompassed within the right to refuse treatment, or would it be obligated to treat the continued operation of the feeding tube or respirator as an ongoing invasion?

If a physician prescribes a mentally competent, terminally ill patient a lethal dose of painkillers in violation of state law, may the State use force -- for example, could the State pump the patient's stomach -- to counteract the effect of the drug? *Cf. Rochin v. California*, 342 U.S. 165 (1952). In other words, is the State free to act to restore the status quo that existed prior to the illegal act, or must it ignore the antecedent violation and avoid what would now constitute a bodily invasion?

In the practice known as "terminal sedation," a physician prescribes a sufficient quantity of sedative to induce coma, but does not then treat the accompanying depression of respiration or inability to ingest; as a result, the patient dies by asphyxiation, starvation or dehydration. *See Terminal Sedation in the Care of Dying Patients*, Archives Internal Med. (Sep. 9, 1996) (WL, AMA-JNLS database). Is this practice encompassed within the rubric of the right to refuse medical treatment, as the American Medical

Association contends? Brief of the American Medical Association, *et al* at 12-13 (No. 96-110).

Should the Court reverse the judgments below, there will be no way to avoid answering questions such as these. When such questions reach this Court, commitment to principled interpretation will require that they be faced. There is simply no way around the hard truth that difficult lines must be drawn, *regardless of how the Court rules in these cases.*

Nevertheless, as we have argued above, the Court need not attempt to resolve all of the difficult constitutional questions presented by state regulation of end-of-life decisions. It is sufficient to note here that the blanket bans of New York and Washington go too far. A ruling to that effect would properly place the matter in the hands of the state legislatures.

Although we do not endorse all of Judge Calabresi's creative proposal in the court below, *see Quill*, 80 F.3d at 738-43 (Calabresi, J., concurring) (arguing that the court should provisionally invalidate New York's statute and remand to the legislature for a statement of present support), we agree with the fundamental insight underlying his approach: a proper understanding of American constitutionalism recognizes that the judiciary and elected representatives share responsibility for interpreting foundational norms. This Court, along with the lower federal courts and state courts, must not hesitate to declare invalid laws that go beyond the proper bounds of legislative authority. At the same time, however, there is a substantial gray area in which elected bodies should be permitted to pursue legitimate governmental objectives that touch upon the exercise of constitutional rights. *See Casey*, 505 U.S. at 873 ("not every law which makes a right more difficult to exercise is, ipso facto, an infringement of that right.")

There exists a significant variety of measures that would protect the State's legitimate interests without unduly burdening the ultimate decision of a mentally competent, terminally ill patient to seek a willing physician's aid in dying. Many of these measures have been proposed as bills in the legislatures of the several States. *See* Appendix A. A ruling by this Court affirming the judgment below would in no way impair this ongoing legislative process. Quite to the contrary, a properly narrow ruling would send the signal to the state legislatures that where constitutional liberty is concerned, they cannot paint with an extremely broad brush; nor can

they use talismanic categories as a substitute for reasoned judgment. As legislators with a sworn duty to uphold the Constitution and an obligation to protect the interests of all persons subject to our laws, we would welcome such a signal.

Conclusion

For the foregoing reasons, the judgments of the Courts of Appeals for the Second and Ninth Circuits should be affirmed.

Respectfully submitted,

Michael C. Dorf, 435 W. 116th Street, New York, N.Y. 10027, (212) 854-2672.

Sherry F. Colb,* 15 Washington Street, Newark, N.J. 07102, (201) 648-1127.

Attorneys** for Amici Curiae

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* Counsel of Record

** We were assisted in the preparation of this brief by Columbia Law School students Stephen Gale Dick, Christian Halliburton and Daniel Spilo.

APPENDIX A

Recent Proposals and Enactments

This Appendix summarizes various proposals recently introduced for consideration in jurisdictions throughout the United States.

DEATH WITH DIGNITY PROPOSALS

At least eight States have considered adoption of similar legislation patterned after Oregon's "Death with Dignity Act," Or. Rev. Stat. §§ 127.800 *et seq* (1995). The current model state proposal differs in some respects from the Oregon statute, which is summarized separately below).

* **Status**: States in which the legislation has been proposed include the following:

- Arizona, S.B. 1007. Introduced January 8, 1996; to committee January 16, 1996.
- California, S.B. 1310 and A.B. 1080. Introduced February 23, 1995; died in committee, January 31, 1996.
- Colorado, H.B. 1185-96. Introduced January 1, 1996; referred to Committee; action postponed indefinitely, February 2, 1996.
- Maine, H.P. 552. Introduced March 7, 1995; House Committee on Judiciary votes not to recommend passage on June 14, 1995.
- Massachusetts, H.B. 3173. Introduced February 14, 1995.
- New Hampshire, H.B. 339. Introduced January 5, 1995; failed in House, January 4, 1996.
- Mississippi, H.B. 1023. Introduced January 22, 1996; died in committee February 6, 1996.
- Vermont, H.B. 335. Introduced February 21, 1995.

* **Summary**: Would allow competent adult suffering from terminal illness to request self-administered lethal dosage of medication; authorize physician to prescribe lethal dose; set forth safeguards, procedures, immunities, and liabilities with respect to fulfilling such request; and make provision of aid in dying by hospital or physician voluntary. Would not authorize active euthanasia, lethal injection, or mercy killing.

* **Safeguards**:

Confirmation of Diagnosis:
- Second opinion by qualified physician required as to diagnosis and prognosis required.

Consideration of Alternatives:
- Primary physician must discuss all feasible alternatives to aid in dying with patient.

Patient's Competence:
- Two physicians must confirm competence.
- Primary physician must refer patient to counseling if deemed necessary.

Voluntary and Informed Decision:
- Patient must make one written and two oral requests. Second oral request must be at least 15 days after written request. Physician must wait at least 48 hours after final oral request to write prescription.
- Before issuing prescription, physician must confirm that patient has made an informed request, and must offer patient opportunity to revoke request.
- Patient may revoke request at any time and in any manner.
- Requires two witnesses to patient's request; one witness shall not be related to or in a position to benefit from patient's death.

Prevention of Coercion:
- Provisions in wills and other contracts, as well as insurance and annuity coverage and benefits, cannot be made contingent on patient's making request for aid in dying.
- Criminal penalties when any of the following result in patient's death: forgery or alteration of request for medication, concealment or destruction of revocation of request, or coercion or undue influence on patient to request medication.

Recording Requirements
- Patient's medical file must include documentation of: all oral and written requests; determination by two physicians of patient's diagnosis, prognosis, and competence, and the voluntary nature of the request; counseling sessions; and the physician's offer to rescind patient's request.
- Above information will not be available to public.
- State will conduct annual review of sample of records.

ADDITIONAL PROPOSALS AND ENACTMENTS

ALASKA -- H.B. 371:

* **Status**: Introduced January 8, 1996

* **Summary**: Would allow competent adult suffering from terminal illness to request self-administered lethal dosage of medication, and authorize physician to prescribe lethal dose. Does not authorize active euthanasia, lethal injection, or mercy killing.

* **Safeguards**:

Confirmation of Diagnosis:
- Second opinion by qualified physician required as to diagnosis and prognosis.

Consideration of Alternatives:
- Primary physician must discuss feasible alternatives to aid in dying and offer alternatives immediately prior to issuing prescription.

Patient's Competence:
- Two physicians must determine that patient is mentally competent.

Voluntary and Informed Request:
- Patient must make one written and one oral request, with 10-day waiting period between requests.
- Following oral request, physician must confirm that patient has made an informed decision and offer patient the chance to revoke the request.
- Patient may revoke request at any time in any manner.
- Two witnesses must attest that patient has made voluntary and informed decision. Neither witness can: be related by blood; entitled to a portion of the patient's estate; have a creditor's claim against patient or estate; be the patient's physician or employed by the patient's health care provider.

Prevention of Coercion:
- Provisions in wills and other contracts, as well as insurance and annuity coverage and benefits, cannot be altered or made contingent on patient's making request for aid in dying.
- Criminal penalties when any of the following result in patient's death: forgery or alteration of request for medication, concealment or destruction of revocation of request, or coercion or undue influence on patient to request medication.

Recording Requirements
- Patient's medical records must include documentation of compliance with all safeguards.

CALIFORNIA -- GUIDELINES OF THE BAY AREA NETWORK OF ETHICS COMMITTEES

* **Summary**: The Bay Area Network of Ethics Committees has prepared "Guidelines for Comprehensive Care of the Terminally Ill," including provisions on aiding terminally ill patients to hasten their death. The guidelines acknowledge the difficulty in treating patients facing protracted, painful terminal illness and difficult decisions regarding end-of-life care. The guidelines urge primary care physicians to consider referrals to appropriate hospice programs and/or consultation with physicians experienced in palliative care. When the patient has requested a physician's aid in dying, the group recommends extensive safeguards and quality-of-care guidelines, summarized below.

* **Safeguards**:

Diagnosis
- Physician should obtain second opinion on terminal diagnosis.

Mental Competence
- Physician should confirm that patient is competent and obtain a second opinion as to competence.
- Physicians are urged to seek appropriate aid from other practitioners in medical and mental health communities.

Consideration of Alternatives
- Physician should ensure that patient has access to palliative care.
- Documentation of patient's evaluation by hospice program or palliative care specialist, or of patient's decision to decline such care.

Voluntary and Informed Decision
- Physician should urge patient, where appropriate, to consult family members and other affected parties in making end-of-life decisions.
- Patient should sign two witnessed statements that decision is voluntary and informed. The second should be executed at least 48 hours after the first. Both should be signed before two witnesses who are unrelated to patient and in no position to benefit from patient's death.

- Physician should ensure that patient is aware that request is revocable at any time.

Documentation
- Before writing prescription, physician should confirm that all of the above have been duly documented.

MARYLAND -- H.B. 474

* **Status**: Introduced January 31, 1996.

* **Summary**: Would, *inter alia*, allow a mentally competent adult suffering from painful terminal condition to request aid in dying, set forth procedures and safeguards for carrying out such request, and make participation in aid in dying optional for physicians and hospitals.

* **Safeguards**:

Confirmation of Diagnosis:
- Diagnosis of painful fatal condition by two physicians; physicians may not be partners or shareholders in the same medical practice (except as members of the same HMO).

Consideration of Alternatives:
- Physician must determine that passive withdrawal of life-sustaining medical support or withholding of nutrition and hydration will not alleviate suffering.

Patient's Competence:
- Physician must determine that patient request is not the result of clinical depression.
- Physician may refer patient to counseling if appropriate.

Voluntary and Informed Decision:
- Patient must make three requests, including one written request.
- Requires waiting period of two weeks between first and final requests.
- Request is revocable at any time without regard to mental capacity.

Authenticity of Request:
- Two witnesses to written request must attest that patient appears to be competent and acting voluntarily.

Prevention of Coercion:
- Insurance benefits and health care services may not be made contingent on execution of execute aid-in-dying request.
- Misdemeanor penalties for persons who forge, alter, conceal, or procure through undue influence or coercion an aid in dying

request or revocation of such request.

MICHIGAN -- H.B. 4134:

* **Status**: Introduced, January 17, 1996.

* **Summary**: Would allow qualified patients to make revocable request for aid in dying, defined here as "provision of a lethal agent;" create judicial review of aid-in-dying requests and revocations; create immunities for those who provide aid-in-dying.

* **Safeguards**:

Diagnosis:

- Two physicians must confirm diagnosis.

Consideration of Alternatives:

- Two physicians and one qualified mental health counselor must discuss treatment options with patient.

Patient's Competence:

- Primary physician and psychologist or other physician must determine mental competence.

Voluntary and Informed Decision:

- Qualified counselor must discuss with patient motivations for aid-in-dying request. Three-day waiting period between counseling and provision of aid in dying.
- Written and oral request required, with 15-day waiting period between requests.
- Patient may revoke request at any time and in any manner.

Prevention of Coercion:

- Declares void any contract provision, including insurance plans and wills, that are contingent on execution of aid-in-dying requests; prohibits insurers from refusing coverage, altering policy terms or invoking exemptions on the basis of aid-in-dying requests.
- Felony punishment for forgery, fraudulent inducement or coercion with respect to aid in dying request, or concealment or destruction of revocation of such request, resulting in death.

Additional Safeguards:

- Creates cause of action for specified relatives to clarify status of patient's request, and requires expedited consideration of such actions;
- Allows health facilities to create additional safeguards, and makes provision of aid in dying by health facilities and physicians voluntary.

NEW YORK -- S.B. 5024; [S.B. 1683; A.B. 6333]

* **Status**:

- S.B. 5024: Introduced on May 3, 1995; in Senate Committee on Health as of 1/3/96.
- S.B. 1683: Introduced February 1, 1995.
- A.B. 6333: Introduced on April 22, 1995.

* **Summary**: Would allow competent adult suffering from terminal illness to request self-administered lethal dosage of medication; authorize physician to prescribe lethal dose; establish safeguards and record-keeping procedures for fulfilling aid-in-dying requests; and make provision of aid in dying by hospital or physician voluntary. Does not authorize active euthanasia, lethal injection, or mercy killing.

* **Safeguards**:

Confirmation of Diagnosis:

- Second opinion by qualified physician required as to diagnosis and prognosis required.

Consideration of Alternatives:

- Primary physician must discuss all feasible alternatives to aid in dying with patient.

Patient's Competence:

- Two physicians must confirm competence.
- Primary physician must refer patient to counseling if deemed necessary.

Voluntary and Informed Decision:

- Patient must make one written and two oral requests, with at least 15 days between written request and final oral request. Physician must wait at least 48 hours after final oral request to issue prescription.
- Before issuing prescription, physician must confirm that patient has made an informed request, and must offer patient opportunity to revoke request.
- Patient may revoke request at any time and in any manner.
- Two witnesses, one of whom shall not be related to or in a position to benefit from patient's death, must confirm that patient appears to be competent and acting voluntarily.

Prevention of Coercion:

- Provisions in wills and other contracts, as well as insurance and annuity coverage and benefits, cannot be made contingent on patient's making request for aid in dying.

- Criminal penalties when any of the following result in patient's death: forgery or alteration of request for medication, concealment or destruction of revocation of request, or coercion or undue influence on patient to request medication.

Recording Requirements

- Patient's medical file must include documentation of: all oral and written requests; determination by two physicians of patient's diagnosis, prognosis, and competence, and the voluntary nature of the request; counseling sessions; and the physician's offer to rescind patient's request.

OREGON -- Or. Rev. Stat. §§ 127.800 *et seq.* (1995)

* **Summary**: Allows competent adult diagnosed with terminal illness to make voluntary, informed request for medication to end his or her life; specifies the form of written request; and sets forth safeguards, procedures, immunities, and liabilities with respect to honoring such request; administration of request for lethal medication is voluntary for health care providers and organizations.

* **Safeguards**:

Diagnosis:

- Diagnosis of terminal illness must be made by two physicians.

Consideration of Alternatives:

- Attending physician must discuss feasible alternatives, including comfort care and pain control, with patient.

Patient Competence:

- Determination of mental competence must be made by two physicians;
- Attending and consulting physician each under duty to refer patient to counseling if deemed necessary.

Voluntary Decision:

- Physicians must confirm that patient's decision is voluntary when making diagnosis and immediately prior to issuing prescription.
- Two witnesses, one of whom may not be related to patient by blood, entitled to a portion of patient's estate, or an owner or employee of facility treating patient, must attest that patient is acting voluntarily.
- Patient must make one written and two oral requests, with at least 15 days between written request and final oral request. Physician must wait at least 48 hours after final oral request to

issue prescription.

- Patient may rescind request at any time and in any manner, without regard to mental state.
- Physician must offer patient opportunity to rescind request before writing prescription.

Coercion

- Provisions in contracts or wills that would affect a person's decision whether to make or rescind a request under this statute are invalid.
- No contractual obligations, insurance or annuity policies can be conditioned or affected by making or rescission of request.
- Forgery or alteration of request for medication, and concealment or destruction of rescission of such request, with intent or effect of causing death, is a felony.
- Coercion or undue influence with respect to request or rescission, with intent or effect of causing death, is a felony.

Recording Requirements

- Patient's medical file must include documentation of: all oral and written requests; determination by two physicians of patient's diagnosis, prognosis, and competence, and the voluntary nature of the request; counseling sessions; and the physician's offer to rescind patient's request.

RHODE ISLAND -- S. 2985.

* **Status**: Introduced February 6, 1996.

* **Summary**: Would authorize physicians to help competent adults suffering from terminal or intractable and unbearable illness to obtain the medical means of suicide, and to assist patient in administration of such means.

* **Safeguards**:

Confirmation of Diagnosis:

- Second opinion required as to diagnosis and prognosis.

Consideration of Alternatives

- Physician must offer alternative treatments, including palliative or hospice care, as well as counseling, and must discuss thoroughly diagnosis and prognosis.

Patient's Competence:

- Written opinion from qualified mental health professional as to patient's competence.

Voluntary and Informed Decision
- Requires two requests by patient, at least 14 days apart; second request must be no more than 72 hours before physician provides patient with medical means of dying.
- Consulting physician and mental health professional must confirm in writing that patient is acting voluntarily.
- Witness must confirm that physician has presented patient with information concerning treatment options and that patient is acting voluntarily.

Prevention of Coercion
- Prohibits insurers, health plans and providers from making services or benefits contingent on request for physician-assisted suicide. Patient's use of aid in dying will not be deemed suicide for insurance purposes.

Recording Requirements
- Patient's medical records must include documentation of compliance with all safeguards.

WASHINGTON -- S.B. 5596

* **Status**: Introduced January 27, 1995.
* **Description**: Would allow a competent, terminally ill adult to make a voluntary, revocable request for physician to prescribe lethal dose of medication to be self-administered by patient; authorize health care providers to participate in aid-in-dying requests.
* **Safeguards**:

Diagnosis:
- Two physicians must independently agree on diagnosis.

Consideration of Alternatives
- Both primary and consulting physician must discuss with patient feasible alternatives to aid in dying.
- Immediately prior to issuing prescription, physician must confirm that patient has been offered all treatment alternatives.

Patient Competence
- Consulting physician to make independent determination of competence

Voluntary and Informed Decision
- Request must be made in writing or on videotape in the presence of two witnesses, neither of whom is related to patient or stands to benefit from patient's death.
- Request for aid in dying may be revoked at any time through

various means.
- Insurance and health plan coverage, benefits and treatment cannot be made contingent upon request for aid in dying.
- Undue influence upon patient to request aid in dying, including through persuasion that patient is financial or emotional burden, punishable as misdemeanor or, if death results, as felony.
- Fraud, forgery, or falsification as to aid in dying request, and concealment or destruction of revocation of such request, punishable as misdemeanor or, if death results, as felony.

WISCONSIN -- A.B. 174, S.B. 90

* **Status**: Introduced April 2, 1995.
* **Summary**: Permits competent adults suffering from terminal illness to make voluntary request for medication to end life.
* **Safeguards**:

Diagnosis:
- Second opinion required as to diagnosis and prognosis.

Consideration of Alternatives:
- Physician must inform patient of feasible alternatives.

Patient's Competence
- Physician must refer patient for counseling if deemed appropriate by either primary or consulting physician.

Voluntary Nature of Request
- Patient must make three requests: an oral request, followed at least 15 days later by a written request, followed by a second oral request. At least 48 hours must elapse between final request and issuance of prescription.
- Patient may revoke request at any time in any of several specified ways.
- Three witnesses, none related by blood, entitled to a portion of patient's estate, or financially responsible for patient's health care.

Prevention of Coercion
- Criminal penalties for forgery or falsification of aid-in-dying request, or concealment of knowledge of rescission of such request.
- Patient may not be required to make an aid-in-dying request as a condition for receipt of health care.

Recording Requirements
- Patient's medical file must include documentation of: all oral

and written requests; determination by two physicians of patient's diagnosis, prognosis, and competence, and the voluntary nature of the request; counseling sessions; and the physician's offer to rescind patient's request.

APPENDIX B

List of *Amici*

Name	State
Representative Kay Brown	Alaska
Representative John Davies	Alaska
Senator Johnny Ellis	Alaska
Representative David Finkelstein	Alaska
Representative Cynthia Toohey	Alaska
Senator Peter Goudinoff	Arizona
Representative Peggy Lamm	Colorado
Senator George Jepsen	Connecticut
Representative Mike Lawlor	Connecticut
Senator Edith Prague	Connecticut
Representative Wendy Jaquet	Idaho
Representative Sara Feigenholtz	Illinois
Representative Barbara Flynn Currie	Illinois
Representative Fred Richardson	Maine
Representative Barbara Dobb	Michigan
Representative Jan Dolan	Michigan
Representative Susan Grimes-Munsell	Michigan

Senator Ernie Chambers	Nebraska
Senator Liz Stefanics	New Mexico
Senator Franz Leichter	New York
Senator Ron C. Cease	Oregon
Representative Edith Ajello	Rhode Island
Representative David Cicilline	Rhode Island
Senator Rhoda Perry	Rhode Island
Senator John Roney	Rhode Island
Senator Charles Walton	Rhode Island
Representative Alan Bjerke	Vermont
Representative Lynn Bohi	Vermont
Representative Dean Corren	Vermont
Senator Jeanne Kohl	Washington
Representative Ed Murray	Washington
Representative Helen Sommers	Washington
Senator Pat Thibaudeau	Washington
Representative Georgette Valle	Washington
Representative Tammy Baldwin	Wisconsin
Senator Fred Risser	Wisconsin